APPLICATION FOR A SQUADRON, GROUP or WING CAP ACTIVITY - EXCEPT ENCAMPMENTS

FILL IN THE FOLLOWING PAGES AS ACCURATELY AND COMPLETELY AS POSSIBLE. PLEASE TYPE OR PRINT NEATLY.
IF FORMS ARE NOT LEGIBLE, THEN YOU MAY NOT BE SELECTED FOR THIS ACTIVITY

NAME (Last Name, First Name, Middle Initial) | JOINED CAP: MM YY | CAP ID Card Good Thru Date

CAP SERIAL NUMBER | SOCIAL SECURITY NO. | CAP GRADE | UNIT CHARTER NUMBER | UNIT NO. | GROUP

MAILING ADDRESS (Number and Street)

TELEPHONE
Home):

(City) | (State) | (Zip Code)

Alternate):

DATE OF BIRTH: MM DD YY | HEIGHT | WEIGHT | GENDER | HAIR COLOR | EYE COLOR

(Cell):

GRADE IN SCHOOL | RELIGIOUS PREFERENCE | E-MAIL ADDRESS

MEDICAL INFORMATON - TO BE COMPLETED BY ALL APPLICANTS

This information is for Official Use Only and will not be released to unauthorized persons. Answer all questions as accurately as possible so that activity staff can make themselves aware of any per-existing medical problems and be alert to help you.

DO YOU CURRENTLY USE ANY MEDICATIONS? (Including eye drops) ___NO ___YES (List any medications taken and the reason in the remarks section.)

NOTE: BRING ALL MEDICATIONS YOU TAKE - IN THE ORIGINAL CONTAINER

HAVE YOU HAD OR HAVE NOW ANY OF THE FOLLOWING? (If yes is answered on any items, please explain why in the remarks section with dates and physician(s) consulted (if any). Items not specifically noted below having the potential to interfere with performance during the activity should be documented in the remarks section.)

☐ NO ☐ YES	Frequent or severe headaches	☐ NO ☐ YES	Ear infections	☐ NO ☐ YES	Chronic diseases like Diabetes or Bronchitis
☐ NO ☐ YES	Dizziness or fainting spells	☐ NO ☐ YES	Rupture	☐ NO ☐ YES	Girls only - Menstrual cramps
☐ NO ☐ YES	Unconsciousness for any reason	☐ NO ☐ YES	Positive TB skin test	☐ NO ☐ YES	Other illness or accidents
☐ NO ☐ YES	Eye trouble, excluding glasses	☐ NO ☐ YES	Epilepsy or fits /seizures	☐ NO ☐ YES	Home sickness
☐ NO ☐ YES	Hay fever	☐ NO ☐ YES	Kidney stones or blood in urine	☐ NO ☐ YES	Chronic or recurring injuries
☐ NO ☐ YES	Sugar or albumin in urine	☐ NO ☐ YES	Motion sickness	☐ NO ☐ YES	Asthma
☐ NO ☐ YES	Heart trouble	☐ NO ☐ YES	Nervous trouble of any sort	☐ NO ☐ YES	Use inhaler? If yes, explain.
☐ NO ☐ YES	High or low blood pressure	☐ NO ☐ YES	Any known allergies	☐ NO ☐ YES	Medical treatment within the last 5 years other than regular office visits or physicals
☐ NO ☐ YES	Stomach trouble	☐ NO ☐ YES	Any drug or narcotic habit	☐ NO ☐ YES	Attempted suicide

Do you have any other medical conditions or problems? ___NO ___YES If YES,
PLEASE LIST AND EXPLAIN IN THE REMARKS SECTION BELOW

FAMILY PHYSICIAN (Name, address, and phone number) phone number

INSURANCE INFORMATION

☐ Medical
Company
Policy Number

☐ Liability
Company
Policy Number

REMARKS - Add sheet of paper if necessary.

CONTINUED ON NEXT PAGE

ACTIVITY: _____

DATE(S) OF ACTIVITY: _____

LOCATION: _____

Host installation mission requirements may result in short-notice changes precluding use of facilities and services; therefore, personnel should possess sufficient funds to defray cost of commercial, off-base lodging and meals should this event occur. If travel is by military airlift, mission requirements may preclude military return airlift; therefore, travelers should possess sufficient funds to defray return travel by commercial mode. Parents/guardians/custodians are responsible for reimbursing CAP or Senior Members for any expenses incurred on behalf of your cadet for any CAP Activity.

RELEASE AGREEMENT

KNOW ALL MEN BY THESE PRESENTS that I am submitting my application a for Civil Air Patrol Activity, and I hereby volunteer entirely upon my own initiative, risk and responsibility for an assignment to participate in this activity at the first available opportunity and with full knowledge that such activity may include:

1. Traveling by land, sea or air in US military, commercial, or privately owned vehicles from regular place of residence to the site of the activity, travel incident to the activity, and subsequence return to place of residence.
2. Participation in aeronautical activities as a passenger or as a student trainee in US military, commercial, or privately owned aircraft.
3. Living for a period of one week or more on diminished rations and minimal shelter simulating actual survival conditions.
4. Being quartered and/or subsiding away from regular or normal place of residence for and extended period of time.
5. Remaining with the cadet group I am assigned to at all times during the activity.
6. Acting as a spokesperson for Civil Air Patrol, rendering reports on the activity.
7. Refraining from argumentative discussions concerning governmental policies.

In consideration of the permission extended to me by the Civil Air Patrol/United States of America through its officers and agents to participate in said activity, I do hereby for myself, my heirs, executors, and administrators release and forever discharge the Civil Air Patrol, Inc./United States of America, and all of its officers, agents, and employees acting officially or otherwise, from any and all claims, demands, or causes of action, on account of my death or on account of any injury to me or my property which may occur as a result of negligence of the Civil Air Patrol/United States of America, its agents or employees during said activity or continuances thereof, as well as all ground and flight operations incident thereto.

PRINTED NAME OF APPLICANT _____ DATE _____ SIGNATURE OF APPLICANT _____

RELEASE BY PARENT OR GUARDIAN/CUSTODIAN

KNOW ALL MEN BY THESE PRESENTS: WHEREBY my child/ward has applied for the activity referred to above. In consideration of the permission extended to my child/ward by the Civil Air Patrol/United States of America through its officers and agents to participate in said activity, I do hereby for myself, my heirs, executors, and administrators release an forever discharge the Civil Air Patrol/United States of America, and al its officers, agents and employees acting officially or otherwise, from any and all claims, demands, actions, or causes of action, on account of the death or on account of any injury to my child/ward which may occur as a result of the negligence of the Civil Air Patrol/United States of America, its agents or employees during said activity or continuances thereof, as well as all ground and flight operations incident thereto. In addition, by my signature below, I certify the applicant:

1. Is my minor child or ward.
2. Has no history of injury or disease which might be affected by this activity except those previously noted in the Medical Information section of the form.
3. Will follow all rules, regulations, and directives as established by Civil Air Patrol, Inc., activity project officer or other staff members. If not following the above mentioned rules, regulations, and directives he/she may be sent home at the discretion of the project officer or activity director at my expense.

However, in case of injury, disease or other illness, permission is hereby granted to treat the applicant as required, and if the applicant is released from the activity before recovery from said injury, disease, or illness, further treatment will be provided by myself.

DATE _____ WITNESS FOR FATHERS SIGNATURE _____ SIGNATURE OF FATHER OR LEGAL GUARDIAN/CUSTODIAN _____

WITNESS FOR MOTHERS SIGNATURE _____ SIGNATURE OF MOTHER OR LEGAL GUARDIAN/CUSTODIAN _____

PRINTED NAMES OF PEOPLE WHO SIGNED THIS RELEASE _____

EMERGENCY ADDRESSEE - PARENT, GUARDIAN, OR CLOSEST RELATIVE TO BE NOTIFIED IN CASE OF EMERGENCY

Name	Relationship
Address	Day Telephone - Indicate if CELL Phone / Night Telephone - Indicate if CELL Phone

ALTERNATE EMERGENCY PERSON T BE NOTIFIED - IF PARENTS CAN NOT BE LOCATED - Relationship _____

Name	Day Telephone - Indicate if CELL Phone	Night Telephone - Indicate if CELL Phone

SQUADRON CERTIFICATION

I certify that the applicant is qualified to attend this Squadron, Group or Wing CAP Activity

SIGNATURE of SQUADRON COMMANDER, DEPUTY COMMANDER, or DEPUTY COMMANDER CADETS _____ DATE _____